Summary report on the

Twenty-ninth intercountry meeting of national managers of the Expanded Programme on Immunization and sixteenth intercountry meeting on measles and rubella control and elimination

WHO-EM/EPI/347/E

Amman, Jordan
29 November–3 December 2015

World Health Organization
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1. Introduction

The WHO Regional Office for the Eastern Mediterranean organized the 29th intercountry meeting of national managers of the Expanded Programme on Immunization and 16th intercountry meeting on measles/rubella control and elimination in Amman, Jordan from 29 November to 3 December 2015.

The objectives of the meeting were to: review country progress towards achieving the regional immunization targets, including routine immunization, measles elimination and hepatitis B control targets; review country progress in implementation of the national plans and update the national plans for strengthening routine immunization, measles/rubella elimination and control and hepatitis B control programme; and review the introduction of inactivated polio vaccine (IPV) into routine immunization programmes in countries and preparations for switching from trivalent oral poliovaccine (tOPV) to the bivalent form (bOPV) in 2016 and update related national plans

The meeting was attended by delegates from 21 countries of the Eastern Mediterranean Region, members of the Regional Technical Advisory Group on Immunization and national technical advisory groups, WHO staff from country, regional and headquarters levels, as well as representatives of different partners including the United Nations Children's Fund (UNICEF), Gavi, the Vaccine Alliance, U.S. Centers for Disease Control and Prevention (CDC), Bill and Melinda Gates Foundation, Network for Education and Support for Immunization, Agence de Médecine Préventive and Eastern Mediterranean Public Health Network. Dr Najwa Khori (Jordan) and Dr Zein Eddine Karar (Sudan) chaired the meeting.

Dr Maria Cristina Profili, WHO Representative in Jordan, inaugurated the meeting and delivered a message from Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Alwan referred to the regional eradication, elimination and control targets and underlined that reaching high routine immunization coverage in all districts, introducing new lifesaving vaccines and technologies and implementing the accelerated disease control strategies were the key pillars for achieving these targets. He drew attention to major challenges facing the Region in connection to the geopolitical situation in several countries and their impact on vaccine delivery systems in the Region and expressed appreciation for the efforts and innovative approaches undertaken in order to keep EPI functioning and to overcome the challenges. While commending the achievements of immunization programmes in many countries, Dr Alwan noted that much still remained to be done in order to achieve regional and global targets.

The meeting was structured as plenary sessions with discussions and group work. The working groups discussed: achieving required population immunity and its impact on measles and rubella occurrence; measles and rubella surveillance; the polio endgame strategic plan, including IPV introduction and switching from tOPV to bOPV in routine immunization; and the regional vaccine action plan. The recommendations of the meeting were drawn from the discussions, and participants actively participated in commenting, modifying and refining the recommendations.

2. Conclusions

Participants expressed appreciation for the efforts of the national immunization programmes and the dedication of the front-line health

workers in the countries in crises, particularly in reaching the children in the hard-to-reach areas with lifesaving vaccines.

Several countries were recognized for successfully controlling measles outbreaks through implementation of wide age-range supplementary immunization activities. Participants congratulated Egypt for the successful implementation of the measles and rubella supplementary immunization activities and commended Egypt and the United Arab Emirates for the successful approach in dealing with vaccine hesitancy during supplementary immunization activities.

Participants recognized the high quality of measles/rubella surveillance and achievement of the main targets of the surveillance system indicators in several countries. Implementation of measles/rubella surveillance was successful in the Syrian Arab Republic and Yemen despite the challenging situations.

Participants noted the progress in the interruption of wild poliovirus transmission in the Middle East and the Horn of Africa and the decrease in polio cases in Pakistan and Afghanistan. Nevertheless, they expressed concern about the difficulty and insecurity the polio teams are facing in this phase of the polio endgame. Most countries made good progress in IPV introduction and plans for the switch from tOPV to bOPV in April 2016.

Many countries have successfully introduced new vaccines and there is good progress towards achieving the hepatitis B control target. However, concern was expressed over the growing threat of vaccine hesitancy in countries and the meeting noted that the Region is not on track for achieving 4 of the regional immunization goals (high routine immunization, polio eradication, measles elimination and neonatal

tetanus elimination) and that these goals were unlikely to be achieved in 2015.

In addition to issuing a number of recommendations below, participants emphasized the importance of accelerating implementation of the recommendations of previous meetings.

3. Recommendations

Strengthening routine immunization

1. Countries that have not yet achieved the routine immunization coverage target (at least 90% DTP3-containing vaccine coverage at national level and 80% in all districts) should, with support from WHO and partners, conduct in-depth analysis of district level immunization data to identify the unreached populations and develop/update district microplans with innovative approaches tailored to reach unimmunized and under-immunized populations, including those in hard-to-reach areas to ensure equity in access to immunization.
2. Countries should develop and implement appropriate communication and social mobilization strategies to raise community awareness, address cultural barriers and increase and maintain the highest level of demand for immunization. National immunization programmes are to engage with civil society organizations, professional organizations, religious leaders (expanding on the experience of engaging religious leadership in the Region in polio eradication), partners, advocates and champions to enhance trust in vaccines and convey messages on the value of vaccines and the responsibility of individuals, parents and community to ensure that everyone is protected through vaccination.

3. Immunization programmes in all countries should create partnerships and continuously engage with the media, social media and other communication routes to sustain awareness of the public on the benefits of vaccines and vaccination.
4. All countries are encouraged to register all available WHO prequalified vaccines (including bOPV and IPV), in order to ensure availability of alternate sources of vaccine supply in case of shortage of any vaccines used by the national EPI.
5. WHO and UNICEF are requested to work with partners to encourage manufacturers to apply for registration of all WHO prequalified vaccines (as relevant) in all Member States.

Implementation of vaccination under humanitarian emergencies

6. WHO should support the countries facing humanitarian emergency to document the successful strategies, innovative approaches and the lessons learnt in delivery of routine vaccines and implementation of supplementary immunization activities during the humanitarian emergency situations and share the successful experiences with the countries facing similar situations.
7. International partners should identify local partners who can deliver vaccination in the inaccessible conflict areas and support them to deliver routine immunization and supplementary immunization activities through the existing coordination mechanisms.
8. International partners should assist, through existing coordination mechanisms, with mapping of areas where immunization services are interrupted, developing necessary plans for implementation of supplementary immunization activities and resuming immunization service delivery, support resource mobilization and support strengthening the local capacity to deliver immunization services.

9. National immunization programmes should harmonize schedules for immunization to ensure equitable access to immunization services for all antigens in all areas of the country.
10. Countries should institute monitoring and evaluation programmes to ensure quality of the services delivered.

Reducing vaccine hesitancy and increasing vaccine demand

11. Immunization programmes are encouraged to assess perceptions, barriers and enablers for increasing vaccination coverage among caregivers and care providers and actively monitor vaccine hesitancy and refusal groups. Countries should assess the best communication approaches to provide vaccines and vaccination-related information.
12. All countries should develop and implement comprehensive communication and social mobilization strategies to increase community awareness about the risks of vaccine-preventable diseases and the benefits of vaccination and to enhance trust in the immunization programme and address concerns using both traditional and new social communication platforms.
13. Immunization programmes should ensure the availability of an EPI-trained communication officer and conduct specialized education and training of health care workers on communication skills to rapidly address vaccine hesitancy issues with clients and parents.
14. Immunization programmes should create close collaboration, coordination and partnership with the private sector, paediatric and other medical societies to counter vaccine hesitancy messages and address vaccine hesitant behaviours among health care workers and the general public. Relevant training should be included in academic and clinical curricula of nursing, medical

and other health care professional students and incorporated into continuing education curricula.

15. WHO should develop its human resource and technical capacity for dealing with the growing problem of vaccine hesitancy in the Region and provide, in collaboration with partners, the necessary technical support to respond to vaccine hesitancy, conduct the related operational research and build the capacity of health workers.

Polio eradication

16. WHO and the partners should support Member States in field testing polio preparedness and response plan and conduct training on the outbreak response standard operating procedures
17. Middle East and Horn of Africa countries should use the assets, knowledge and infrastructure of the polio eradication initiative in improving routine immunization coverage through promotion and implementation of the Eastern Mediterranean Vaccination Action Plan and in responding to national public health emergencies like cholera or measles outbreak response, mass exodus, etc.
18. All countries to enhance the sensitivity of the surveillance system and immunization coverage of high risk populations particularly the children of internally displaced people, refugees and migrant communities from polio endemic countries

Implementation of objective 2 of polio eradication end game strategic plan

19. Egypt, Iraq and Djibouti should prepare for introduction of IPV, including, as necessary, cold chain capacity assessment and cold chain capacity upgrading, reviewing the registration and reporting

system as well as training of the immunization health workers at all levels.

20. WHO should support countries in the registration of bOPV according to updated WHO guidelines and in implementation of fast track registration of IPV.
21. All countries should adhere to the dates of the globally coordinated switch period (17 April to 1 May 2016). Countries that have not yet decided on the switch day should do so and notify WHO, UNICEF, and partners on the switch day soon.
22. Egypt, Iraq, Libya and the Syrian Arab Republic should develop national plans of action for the switch in line with related WHO guidance, and share national switch plans with WHO, UNICEF, and partners by 15 December 2015.
23. All countries should regularly follow up on national preparations for implementation of the switch, using the switch planning dashboard, to ensure timely completion of all switch-related activities including thorough validation and reporting to WHO as per switch guidelines.
24. All Member States should ensure they have adequate operational funds and stock of bOPV by the switch date.
25. WHO and partners are requested to provide technical support to countries in need in order to ensure smooth implementation of the switch by the global target date.
26. WHO to support countries in implementing training on the interim and post-switch guidelines to respond to VDPV2

Measles/rubella elimination and control

27. All countries should include a long-term plan for measles elimination in their country multiyear plan and develop and implement annual work plans accordingly.
28. All countries are encouraged to use the new WHO guidelines to conduct high quality measles/rubella supplementary immunization activities, including, readiness assessment tools, intra-campaign performance monitoring and post campaign coverage surveys. Countries should develop plans and ensure budget allocation for mop-up activities based on results of the post campaign evaluation and coverage surveys.
29. Countries should follow the recommendation of the Strategic Advisory Group of Experts on Immunization (SAGE) that infants from 6 months of age receive a dose of measles containing vaccine in the following circumstances:
    a. during a measles outbreak as part of intensified service delivery;
    b. during supplementary immunization activities in settings where risk of measles among infants remains high (e.g. in endemic countries experiencing regular outbreaks);
    c. for internally displaced populations and refugees, and populations in conflict zones;
    d. for individual children at high risk of contracting measles (e.g. contacts of known measles cases or in settings with increased risk of exposure during outbreaks such as child care facilities);
    e. for infants travelling to countries experiencing measles outbreaks;
    f. for infants known to be HIV-positive (see 2009 WHO measles vaccine position paper).

Measles-containing vaccine administered before the age of 9 months should be considered a supplementary dose and recorded on the child's vaccination record as "MCV0". Children who receive a MCV0 dose should then receive subsequent measles-containing vaccines at the recommended ages according to the national schedule.

31. The Regional Office should expedite establishing regional verification commissions for measles/rubella elimination and hepatitis B reduction goals.
32. All countries should establish a national verification committee for measles and rubella elimination in line with WHO guidelines on establishing national measles/rubella verification committees.
33. All countries should establish surveillance systems for congenital rubella syndrome (CRS) and/or CRS disease burden studies. Countries that have not introduced rubella vaccine are to use the data generated for advocacy and decision-making on introduction of rubella vaccine. Countries that have introduced rubella vaccine are to use these data for monitoring progress towards achieving the national rubella/CRS elimination target.
34. WHO and partners should provide necessary technical support for establishing CRS surveillance or conducting CRS disease burden studies, including analysis of data and using the data for decision-making and mobilizing necessary resources for rubella vaccine introduction.
35. All countries should strengthen measles/rubella case-based laboratory surveillance and reach the recommended surveillance system performance indicators. Countries should ensure proper coordination and collaboration between epidemiology and laboratory surveillance departments. Data reported to WHO should be consistent with the data reconciled and coordinated by both the epidemiology and laboratory departments.

36. Provincial EPI teams in Pakistan should share all case-based surveillance data with the Federal EPI cell and the Federal EPI cell should share the comprehensive data with WHO.
37. Member States should collect representative specimens for genotype analysis from all outbreaks and report all sequencing data to the international database.
38. All Member States should conduct in-depth data analysis, provide regular feedback to reporting sources, and develop appropriate responses based on the analysis.
39. To avoid overburdening the laboratory during an outbreak, programmes should enhance epidemiological investigation and linking of cases epidemiologically with laboratory-confirmed cases following WHO guidelines. Once an outbreak has been confirmed, further testing should be done every three months or if the outbreak appears in new areas.
40. Countries that face difficulty in specimen transportation within the county or outside the country, including cold chain maintenance, are encouraged to use alternative sampling techniques such as dry whole blood on filter paper spots or oral fluid collection device, which can withstand ambient temperature for around a week.
41. WHO should continue providing the necessary support to strengthen and sustain high quality testing, including, providing training opportunities and monitoring laboratory performance including serology and molecular quality assurance.

Eastern Mediterranean Vaccine Action Plan (EMVAP)

42. Countries should update their multiyear plans in line with the EMVAP and develop annual immunization workplans in line with the multiyear immunization plan.

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